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FINAL

Ms. Margaret Liston
Chief, Financial Management Section
California Department of Health Care Services
Medi-Cal Managed Care Division
1501 Capitol Avenue, PO Box 997413
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Sacramento, CA 95899-7413

November 8, 2010

Subject: Two-Plan Model contract year 2011 rate range development and certification

Dear Ms. Liston:

The California Department of Health Care Services (DHCS) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rate ranges for use during the Two-Plan model contract year 2011 (ContractY11) period. The ContractY11 period began October 1, 2010, and ends September 30, 2011. This letter presents an overview of the analyses and methodology used in Mercer's managed care rate range development for the purpose of satisfying the requirements of the Centers for Medicare and Medicaid Services (CMS). Note that this rate range development process constituted a rebasing of the capitation rates. In Mercer's opinion, the capitation rate ranges developed result from an actuarially sound process and should, along with Managed Care Organization (MCO) investment income and any reinsurance or stop-loss cash flows, provide for all reasonable, appropriate and attainable costs. Across all of the Two-Plan MCOs, the mid-point capitation rate change is 8.4% above current rates, weighted on member months from the 2010–2011 budget figure estimates from May 2010.

If you have any questions on the above, please feel free to contact Mike Nordstrom at +1 602 522 6510, Jim Meulemans at +1 602 522 8597 or Branch McNeal at +1 602 522 6599.

Sincerely,

Michael E. Nordstrom, ASA, MAAA James J. Meulemans, ASA, MAAA

MEN/JJM/lgm

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Two-Plan Model
Contract Year 2011
Rate Range Development and Certification

State of California

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Rate methodology

Overview

Capitation rate ranges for DHCS' Two-Plan managed care program were developed in accordance with rate-setting guidelines established by the Centers for Medicare and Medicaid Services (CMS). For rate range development for the Two-Plan Managed Care Organizations (MCOs), Mercer used calendar year 2008 (CY08) Two-Plan MCO-reported encounter data, the CY08 Rate Development Template (RDT) data and other ad hoc claims data reported by the Two-Plan MCOs. The most recently available (at the time the rate ranges were determined) Medi-Cal-specific financial reports submitted to the Department of Managed Health Care (DMHC) were also considered in the rate range development process.

Adjustments were made to the selected base data to match the covered population risk and the State Plan approved benefit package for the contract year 2011 (ContractY11) contract period. Additional adjustments were then applied to the selected base data to incorporate:

- Prospective and historic (retrospective) program changes not reflected (or not fully reflected) in the base data
- Observed changes in the population case-mix and underlying risk of the MCOs from the base data period
- Budget neutral relational modeling for smoothing
- Trend factors to forecast the expenditures and utilization to the contract period
- Administration and Underwriting Profit/Risk/Contingency loading

The above process has been in place for each of the ContractY08, ContractY09 and ContractY10 rate range developments. However, in the ContractY10 rate range development, DHCS took two additional steps in the measured matching of payment to risk:

1. Introduction of a maternity supplemental (kick) payment
2. Introduction of risk-adjusted county average rates

The ContractY11 rate range development also includes the maternity kick payment as well as risk-adjusted county average rates.

A single and consistent process of developing capitation rate ranges was used for the ContractY11 Two-Plan program. DHCS will offer final rates within the actuarially sound rate ranges of each MCO. Each MCO has the opportunity and responsibility to independently review the rates offered by DHCS, and to determine whether the rates are acceptable based on their individual financial requirements.

The various steps in the rate range development are described in the following paragraphs.

Base data

The information used to form the base data for the Two-Plan rate range development was MCO encounter data, requested MCO RDT and ad hoc claims data, and DMHC required Medi-Cal-specific financial reporting. The CY08 encounter and RDT claims data included utilization and unit cost detail by category of aid (COA) group, by county, by MCO and by 12 consolidated provider types or categories of service (COS), including:

- Inpatient Hospital
- Outpatient Facility
- Emergency Room Facility
- Long-Term Care Facility (LTC)
- Laboratory and Radiology
- Physician Primary Care
- Physician Specialty
- Pharmacy
- Federally Qualified Health Center (FQHC)
- Other Medical Professional
- Transportation
- All Other

Utilization and unit cost information from the plan-specific encounter and RDT data was reviewed at the COA group and COS detail levels for reasonableness. Ranges of reasonable and appropriate levels of utilization and unit cost were then established for each COS within each COA group. Averages of the reasonable and appropriate levels were also established for the encounter and the RDT data. This process in essence produced four potential data elements of utilization and unit cost for each COS within each COA group: 1) plan-specific encounter data; 2) plan-specific RDT data; 3) average encounter data; and 4) average RDT data. These four data elements were then applied credibility factors dependent upon the plan-specific data being reasonable and appropriate, and also based on the enrollment size of the population of the COA.

CY08 served as the base data period. All selected base data was adjusted (as appropriate) to reflect the impact of historical program changes within this period. This is discussed further in the “Program changes” section. The DMHC financial reporting Revenue, Expenses and Net Worth exhibits for each MCO that were available at the time the rate ranges were being developed were reviewed and analyzed by DHCS and Mercer for insight into changes in population case-mix and underlying risk.

A requirement of 42 CFR 438.6(c)(4)(ii) is that all payment rates under the contract are based only upon services covered under the State Plan to Medicaid-eligible individuals. As described above, MCO encounter data served as the starting base data for rate setting. Encounters undergo edits within DHCS to ensure quality and appropriateness of the data for rate-setting purposes. Base period MCO eligibility (described below) and encounter data were pulled consistent with service code mappings from DHCS, including lists of excluded services such as abortion. Mercer has relied on data and other information provided by the MCOs and DHCS in the development of these rate ranges. We have reviewed the data and information for reasonableness, and we believe the data and information utilized in the rate development to be free of material error and suitable for rate range development purposes for the populations and services covered under the Two-Plan contracts. Mercer did not audit the data or information and, if the data or information is materially incomplete or inaccurate, our conclusions may require revision. However, Mercer did perform alternative procedures and analysis that provide a reasonable assurance as to the data's appropriateness for use in capitation rate development under the State Plan.

Graduate medical education

With regards to Graduate Medical Education (GME) costs and 42 CFR 438.6(c)(5)(v) (along with item AA.3.8 of "Appendix A. PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting, Edit Date: 7/22/03"), DHCS staff has confirmed that there are no provisions in the Two-Plan managed care contract regarding GME. The Two-Plan MCOs do not pay specific rates that contain GME or other GME-related provisions. As Two-Plan MCO data serves as the base data, GME expenses are not part of the Two-Plan capitation rate development process.

Maternity supplemental (kick) payment

To further enhance the measured matching of payment to risk, DHCS is utilizing a maternity supplemental (kick) payment. Pertaining to gender, the primary issue that could result in significant variance among the Two-Plan MCOs' enrolled population, and hence their risk, is the event of maternity and its related cost. Costs for pregnant women are substantially higher than the average medical cost of care for men and non-pregnant women with similar demographic characteristics. To mitigate the maternity risk issue in rates, DHCS is including a maternity supplemental payment which represents costs for the delivery event. (Pre-natal and post-partum care costs are not part of the kick payment, but remain within the respective COA capitation rates.) A Two-Plan MCO receives the lump sum maternity supplemental payment when one of its current members gives birth and DHCS is appropriately notified that a birth has occurred. Note that non-live birth expense data and non-live birth outcomes were excluded from the maternity supplemental payment analysis and the corresponding development of the ContractY11 maternity supplemental payments. This results in non-live birth expenses being included in the base capitation rates rather than being included in the kick payment.

Maternity kick – design

- Payment made on delivery event that generates a state vital record
- One kick payment per delivery regardless of number of births
- One blended kick payment combining Caesarean and vaginal deliveries
- Kick payment varies by county, but not by MCO within a county
- Kick payment reflects cost of delivery event only (mother and baby, excluding pre-natal and post-partum care)
- Combine prior Adult and Family COA groups
  – Without maternity event, risk of Adult group is similar to Family group
- Carve out maternity costs from Adult & Family and Aged/Disabled Medi-Cal Only COA groups (99.9% of all deliveries)

Maternity kick – rate development approach

- Calculate delivery costs by county
- Calculate delivery costs from CY08 MCO RDT data
  - Same general data selection process used as in regular rate range development
  - Developed smoothed data points to replace missing or unreasonable data and blend with plan-specific data
- Blend reported and smoothed costs from the MCOs to generate county-specific amounts
- Trend base costs forward to the midpoint of the contract period
- Adjust for applicable program changes
- Add load for Administration and Underwriting Profit/Risk/Contingency
- Calculate delivery counts by MCO
  - Rely on Medi-Cal Deliveries Report information generated by DHCS
  - Medi-Cal eligibility is the primary data source
- Calculate historical birth rates by MCO (prior years reviewed for consistency)
- Project number of delivery events based upon birth rates and ContractY11 projected member months for applicable COA groups
- Back dollar amount from Adult & Family and Aged/Disabled/Medi-Cal Only costs by MCO.

Across all Two-Plan MCOs the equivalent PMPM adjustment for the maternity supplemental payment is $12.40 for Adult & Family and $2.26 for the combined Aged/Disabled/Medi-Cal Only COAs.

This methodology is budget neutral, projecting the same total dollar outlays under a pre- and post-maternity supplemental payment approach.

Category of Aid (Aid Code) groupings

The base data sets used to develop the Two-Plan ContractY11 capitation rate ranges were divided into cohorts that represent consolidated COA (or Aid Code) groupings which inherently represent differing levels of risk. These eight COA cohorts are (alphabetically):

- Adult & Family
- Aged/Disabled Medi-Cal Only
- Aged/Dual Eligible
- AIDS/Dual Eligible
- AIDS/Medi-Cal Only
- BCCTP
- Disabled/Dual Eligible
- Maternity

With the use of the maternity supplemental (kick) payment, as well as risk-adjusted county average rates (each described in more detail elsewhere within this certification), DHCS and Mercer were able to combine prior COAs with similar remaining underlying risk. The separate Adult and Family COAs from ContractY09 were combined into Adult & Family, and the separate Aged/Medi-Cal Only and Disabled/Medi-Cal Only from ContractY09 were combined into Aged/Disabled Medi-Cal Only. This same process was used in the ContractY10 rate development process.

Data smoothing

The Two-Plan program is very large, covering over 2.7 million lives. In aggregate, each MCO has a fully credible population base for rate-setting purposes. However, there are a number of MCO COA groups within each county for which there is concern over specific COA group credibility. In those instances, Mercer analyzed data and information on a more aggregate level, and from this developed factors or relativities to overcome any excessive variation brought on by small membership or extraordinary (high or low) utilization or unit costs. Adjustments were made via a budget-neutral relational modeling process. No dollars were gained or lost in this process.

Trend

Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period. As part of the ContractY11 rate range development for the Two-Plan program, Mercer developed trend rates for each provider type or COS, separately by utilization and unit cost components.

Trend information and data were gathered from multiple sources, including MCO encounter and RDT data, MCO financial statements, Medi-Cal fee-for-service experience, historical California Medical Assistance Commission (CMAC) adjustments, Consumer Price Index (CPI) and National Health Expenditures (NHE) updates, and multiple industry reports. Mercer also relied on professional judgment based upon our experience in working with the majority of the largest Medicaid programs in the country. Base data used was trended forward 33 months to the mid-point of the rating period.

Annual mid-point claim cost trends, across all MCOs, all COA groups and all 12 COS, average 0.6% for utilization and 4.1% for unit cost or 4.7% PMPM, an increase of 0.5% from those utilized for the ContractY10 capitation rate ranges. The weighted COS PMPM trends vary from a high of 7.2% for Outpatient Facility (1.0125 for utilization times 1.0591 for unit cost equals 1.072 or 7.2%) to a low of 3.0% for “Physician Specialty.” Note trends for the LTC provider type are displayed as 0.0% for both utilization and unit cost. Due to the relatively high level of legislatively-mandated changes surrounding LTC, Mercer has handled LTC trends through the “Program changes” section of the methodology.

Given the recent financial information available at the time the rate ranges were developed, the range for the claim cost trend component is +/- 0.25% per year for each of the utilization and unit cost components, or roughly +/-0.5% PMPM per year. (The +/- 0.25% does not apply to a 0 value such as those for LTC.) Over the 2.75 years from CY08 to ContractY11, this contributes almost +/- 1.4% to the upper and lower bounds of the rate ranges.

Program changes

Program change adjustments recognize the impact of benefit or eligibility changes that took place during or after the base data period. The program changes incorporated in the development of the rate ranges were based on information provided by DHCS staff. Following are the program changes (with effective dates) that were viewed to have a material impact on capitation rates, and which were reviewed, analyzed and evaluated by Mercer with the assistance of DHCS' Managed Care Division and Fiscal Forecasting and Data Management Branch staff:

- LTC rate adjustments – multiple dates
- Hospice rate increases – multiple dates
- Mirena IUC – July 2008
- Provider payment reduction – July 2008 (reflects all refinements [i.e., injunctions] through March of 2010)
- Post-stabilization services reduction – October 2008
- Discontinuation of adult optional benefits – July 2009
- H1N1 Vaccine – October 2009
- Reinstatement of optometry services – July 2010

Any program changes with an effective date prior to January 1, 2009, were treated as retrospective changes.

Also, effective for the first three months (October 1, 2010, through December 31, 2010) of the ContractY11 period, a legislated policy change, Assembly Bill 1653 (AB 1653), is incorporated into the actuarially sound capitation rate ranges. This policy change increases the Medi-Cal fee-for-service (FFS) inpatient payment levels in total approximately 40% and the Medi-Cal FFS outpatient hospital and emergency room payment levels in total approximately 92%. The associated managed care service category increases, being implemented at approximately 60% of the FFS increase levels, are applied to the managed care inpatient, outpatient hospital and emergency room unit costs. The specific program change for inpatient unit costs is 20.2% and the program change for outpatient hospital and emergency room unit costs is 51.0%.

Since AB 1653 is only effective for the first three months of the ContractY11 contract period, the rate increases caused by this policy change are only applied to the rates for the first three months of ContractY11. This creates two sets of rates that will be paid in ContractY11: the set of rates used for the first three months and the set of rates used for the final nine months of the contract period. The development of these two sets of rates is

identical. The only difference is that the rates used for the first three months have additional increases to account for the AB 1653 policy change.

Because of the size of these increases to the hospital unit costs within the capitation rates, the administrative costs and underwriting profit/risk/contingency PMPM amounts were maintained at the levels established prior to applying the AB 1653 program change.

Efficiency adjustment – Maximum Allowable Cost (MAC)

For the ContractY11 rating period, DHCS is introducing an adjustment to the capitation rates that analyzes the effectiveness of each Two-Plan MCO's pharmacy cost management through a Maximum Allowable Cost (MAC) avoidable cost analysis.

To identify potentially avoidable costs due to reimbursement inefficiencies, Mercer utilized the Two-Plan MCOs' CY08 pharmacy data and reviewed the reimbursement contracting for generic products. Each pharmacy claim was compared against a benchmark Medicaid MAC list for the same timeframe to create a cost savings amount for each claim. To calculate the cost savings amount, a derived paid amount which utilized the unit price from the benchmark MAC list was calculated for each claim and subtracted from the actual paid amount on each claim. The total cost savings for each claim was then combined and aggregated for each MCO to calculate the total cost savings for each MCO. In instances where the actual paid amount was less than the derived paid amount (negative cost savings), the negative amount was counted against the cost savings amount.

In total, across all Two-Plan MCOs and COAs, the midpoint capitation rates were reduced by an amount of $1.22 (-0.9%) as a result of this adjustment.

Risk adjustment

Capitation rates for DHCS' Two-Plan model are risk adjusted using the Medicaid Rx Version 5.2 health-based payment model developed by the University of California at San Diego (UCSD). Risk-adjusted county average rates are blended (20%) with the historical MCO "plan-specific" rate approach (80%) for each Two-Plan model MCO by county. The risk adjustment applies to the Adult & Family and Aged/Disabled/Medi-Cal Only COA groups only. Capitation rates for the Aged and Disabled dual eligible, BCCTP and AIDS COA groups are not risk adjusted. Also, since a separate maternity supplemental payment rate has been developed, maternity costs were excluded from the risk-adjustment process.

Capitation rates for the Aged and Disabled dual eligible, BCCTP and AIDS COA groups are not risk adjusted. The application of risk adjustment to the capitation rates is to better match the payment to the risk. For the Aged and Disabled duals, non-pharmacy- (i.e., diagnosis-) based risk adjustment model, much of the claims history is captured through Medicare, further complicating the use of risk adjustment for dual members. Second, for the Aged and Disabled dual COAs, the majority of the dollars paid for all medical claims are covered by the Medicare benefit. The capitation rates only represent the costs of the services not already covered through Medicare. The current cost weights developed for the Medi-Cal program assume that all managed care covered services are paid by the

Medi-Cal HMOs. Creating a risk-adjustment system for the dual populations would require a unique set of cost weights that account for services paid through Medicare and a methodology to overcome the data issues mentioned above. This additional level of resources with potentially limited benefit of better matching payment to the limited remaining risk for these dual eligible members was not performed. For BCCTP and AIDS, separate capitation payments are already developed for these members with narrowly-defined disease conditions (e.g., breast and cervical cancer) that allow entrance into these COAs. These separate capitation payments developed for the BCCTP and AIDS populations are not risk adjusted since they already appropriately match the payments to the risk.

The individual acuity factors that will be in effect for ContractY11 were based on pharmacy encounters and claims incurred December 1, 2008, through November 30, 2009 (referred to as the study period), with process dates through the end of March 2010. Four months of data lag was used to help complete the pharmacy claims and encounters. DHCS continues to validate encounter data and is working with the MCOs to support and monitor their efforts to continually improve the collection and reporting of encounter data. For example, prior to running the pharmacy encounter data through the Medicaid Rx classification system, the reasonableness of the pharmacy claims and encounter data volume were reviewed by calculating the monthly average number of claims per recipient across the MCOs. Additionally, analyses and reviews were performed on the pharmacy claims and encounters to measure claims without National Drug Code (NDC) information and evaluate the validity of reported NDCs.

DHCS and Mercer used the prospective Medicaid Rx model to evaluate risk differences between the participating Two-Plan model MCOs. The risk-adjustment process only includes experience data for individuals who have at least six months of total Medi-Cal eligibility within the twelve-month study period. Individuals who do not meet the six-month eligibility criterion are assigned the respective MCO's average risk factor associated with that individual's rating group.

Individual acuity factors are developed for each recipient. The individual acuity factors are subsequently aggregated by COA group, MCO and county. To ensure that the risk-adjustment process does not increase or decrease the total amount of capitation payments, the MCOs' risk factors are adjusted for budget neutrality. The intent of this adjustment is to recalibrate all the MCO risk-adjustment factors to yield a population average of 1.0000. Each MCO's own risk-adjustment factors are applied to the county average base capitation rates to arrive at each MCO's risk-adjusted rate. As mentioned earlier, the risk-adjusted county average rates for each MCO are then blended at 20% weight, with the historical MCO "plan-specific" rate approach blended at 80%. We believe this blending approach is appropriate, and is consistent with the risk-adjustment process utilized in the ContractY10 rate development process.

The Medicaid Rx version 5.2 model was recently updated by UCSD in 2010 and has been further adjusted to more closely align with the risk associated with the Two-Plan model covered benefits. For example, the cost weights reflected in the national Medicaid Rx

Version 5.2 model were developed assuming a comprehensive acute care and behavioral health benefit package, and utilized over 30 states' data. Since the model is applied to the Two-Plan program, UCSD staff and Mercer modified the cost weights to reflect California Medi-Cal-specific data and services covered under the Two-Plan managed care program. Please see the separate document "CA Two Plan Methodology Letter Aug 13 2010" for more detail.

Administration and underwriting profit/risk/contingency loading

The administration loading for the Two-Plan model MCOs was developed in aggregate. The administration load factor is expressed as a percentage of the capitation rate (i.e., percent of premium). This mid-point percentage was developed from a review of the MCOs' historical reported administrative expenses. Mercer also utilized its experience and professional judgment in determining the mid-point and lower and upper bound percentages to be reasonable. The mid-point Administration load is 8.9% across all Two-Plan MCOs. The range for the Administration component is +/- 0.9% upper/lower bound from the mid-point value.

While the above is the overall targeted aggregate administrative percentage, the administrative expense associated with each COA group varies from the overall percentage. The administrative component can be viewed in two pieces: a fixed cost component and a variable cost component. The fixed cost component represents items such as accounting salaries, rent and information systems, while the variable cost component represents items such as claims processing and medical management per eligible. Allocating the administrative costs as a uniform percentage of each of the COAs is an appropriate method; however, it does not take into account the differences in fixed versus variable administrative costs for each.

Certain COA groups have capitation rates ten (or more) times larger than other COAs. In these instances, the uniform allocation methodology will produce an administrative component for the more expensive COA ten (or more) times larger than the administrative component for the less expensive COA groups. While a more expensive eligible is probably more administratively intensive, this ten (or more) to one relationship in administrative costs is most likely exaggerated.

If the fixed component of administrative costs is broken down and viewed on a PMPM basis, then this fixed dollar amount is a larger percentage of the capitation rate of the less expensive COA groups, and a smaller percentage of the capitation rate for the more expensive COA groups. This concept has been applied in a budget-neutral fashion (no administrative dollars have been gained or lost) to the capitation rates, whereby the administrative percentage will be greater for less expensive COA groups than the aggregate administrative percentage over the entire population. Similarly, the administrative percentage for the more expensive COA groups will be less than the aggregate administrative percentage over the entire population.

The underwriting profit/risk/contingency load is 3.0% at the mid-point, 2.0% at the lower bound and 4.0% at the upper bound. Mercer has implicitly and broadly considered the cost

of capital within our rating assumptions. Our conclusion is that our assumptions surrounding the underwriting profit/risk/contingency load, as well as income an MCO generates from investments, are sufficient to cover at least minimum cost of capital needs for the typical health plan.

It should be noted that the administrative and underwriting profit/risk/contingency percentages quoted above were applied prior to the inclusion of AB 1653 in the rates effective for October 1, 2010 through December 31, 2010.

Blended "plan-specific" and risk-adjusted county average rates

In an effort to encourage and reward cost efficiencies and effectiveness, for ContractY11 DHCS is using a blended "plan-specific" and risk-adjusted county average rates approach, consistent with the approach that was used for the ContractY10 rate development. As mentioned in the “Risk Adjustment” section, the ContractY11 blend is 20% of the risk-adjusted county average approach, and 80% of the MCO “plan-specific” approach, by county. Each of these separate approaches produces actuarially sound rates or rate ranges, and blending the approaches does not impact actuarial soundness, but enhances DHCS program goals.

“Plan-specific”: The same general methodology employed for the 80% blend in the ContractY10 rate development has been utilized for the 80% blend portion for ContractY11. While a large number of rate-setting factors/components/loads are **not** MCO-specific (items such as utilization trend, unit cost trend, program changes, administration and underwriting profit/risk/contingency are Two-Plan model specific), at the mid-point the medical expense base data has a strong relationship to recent MCO claims experience. For this reason this approach has often been referred to as “plan-specific” rate setting. In spite of the stated caveats, we retain that terminology.

Risk-adjusted county average rates: County-specific rates are developed on a weighted average (using projected ContractY11 member months) basis to maintain budget neutrality. All health plan data/experience in a county considered in the “plan-specific” approach are considered here. The county-specific approach is obviously already done for the DHCS County Organized Health Systems (COHS) model. In Mercer’s opinion, with two or more MCOs in a county, best practice is to also incorporate the use of risk adjustment, where an MCO’s plan-specific budget-neutral risk scores are applied to the applicable county-specific rates.

For ContractY11, this blending applies to the Adult & Family and Aged/Disabled/Medi-Cal Only COAs. The Maternity Supplemental Payment COA was developed on a county-specific basis. All other COA groups, other than the above three, remain “plan-specific.”

Rate ranges

To assist DHCS during its rate discussions with each MCO, Mercer provides DHCS rate ranges which were developed using an actuarially sound process. The COA group-specific

rate ranges were developed using a combination of a modeling process which varied the medical expense (i.e., risk) trend, the administration loading percentage and the Underwriting/Profit/Risk/Contingency loading percentage to arrive at both an upper and lower bound capitation rate. The final contracted rates agreed to between DHCS and each MCO fall within the rate ranges provided by Mercer.

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Rate range certification

In preparing the rate ranges described, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design, and financial data and information supplied by DHCS, its MCOs and its vendors. DHCS, its MCOs and its vendors are responsible for the validity and completeness of this supplied data and information. We have reviewed the data and information for internal consistency and reasonableness, but we did not audit it. In our opinion the data used for the rate development process is appropriate for the intended purposes. If the data and information are incomplete or inaccurate, the values shown in this report and associated exhibits may need to be revised accordingly.

Mercer certifies that the Two-Plan ContractY11 rate ranges, which include the AB 1653 policy change for the rates effective October 1, 2010 through December 31, 2010 and do not include AB 1653 for the rates effective January 1, 2011 through September 30, 2011, were developed in accordance with generally accepted actuarial practices and principles, and are appropriate for the Medi-Cal covered populations and services under the managed care contract. The undersigned actuaries are members of the American Academy of Actuaries and meet its qualification standards to certify to the actuarial soundness of Medicaid managed care capitation rates.

Rate ranges developed by Mercer are actuarial projections of future contingent events. Actual MCO costs will differ from these projections. Mercer has developed these rate ranges on behalf of DHCS to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and accordance with applicable law and regulations. Use of these rate ranges for any purpose beyond that stated may not be appropriate.

MCOs are advised that the use of these rate ranges may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rate ranges by MCOs for any purpose. Mercer recommends that any MCO considering contracting with DHCS should analyze its own projected medical expense, administrative

expense and any other premium needs for comparison to these rate ranges before deciding whether to contract with DHCS.

This certification letter assumes the reader is familiar with the Medi-Cal program, Medi-Cal eligibility rules and actuarial rating techniques. It is intended for DHCS and CMS, and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial rate projections to understand the technical nature of these results.

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